STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155224	B. WING		09/26/2012
NAME OF P	PROVIDER OR SUPPLIEI	- R		T ADDRESS, CITY, STATE, ZIP CODE	
				V COLUMBIA ST	
COLUME	BIA HEALTHCARE	CENTER	EVAN	ISVILLE, IN 47710	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEI TELENCT )	DATE
1 0000					
	This visit was fo	or the Investigation of	F0000	The creation and submission	of
	Complaint IN00	_		this Plan of Correction does r	
	*			constitute an admission by th	
	Complaint IN00	116529- Substantiated,		provider of any conclusion se forth in the statement of	t
	•	ndings related to the		deficiencies, or of any violation	on of
	allegations are cited at F157, F282, F314,			regulation.	
	and F329.			This provider respectfully requests	that
				the 2567 Plan of Correction be	liial
	Survey dates:			considered the Letter of Credible	
	September 24, 2	25, and 26, 2012		Allegation and requests a Post Certification Desk Review in lieu of	a
				Post Survey Revisit on or after Octo	ober
	Facility number	: 000129		8, 2012.	
	Provider number	r: 155224			
	AIM number: 10	00266780			
	Survey team:				
	Anne Marie Cra	ys, RN			
	Census bed type	::			
	SNF/NF: 158				
	Total: 158				
	Census payor ty	pe:			
	Medicare: 26				
	Medicaid: 113				
	Other: 19				
	Total: 158				
	Samula: 24				
	Sample: 24				
	These deficienci	ies reflect state findings			
		nce with 410 IAC 16.2.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

15XK11

TITLE

PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155224	LDING	00	COMPL 09/26/	ETED
	PROVIDER OR SUPPLIER		621 W 0	DDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Quality review of 27, 2012 by Bev	completed on September Faulkner, RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5XK11

Facility ID: 000129

If continuation sheet Page 2 of 24

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED	
		155224	B. WIN			09/26/	2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	8			COLUMBIA ST			
COLUMB	BIA HEALTHCARE (	CENTER			VILLE, IN 47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0157	483.10(b)(11)							
SS=D	NOTIFY OF CHA							
	(INJURY/DECLIN							
		mediately inform the						
	· ·	with the resident's						
	physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the							
resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life								
	threatening condi							
		need to alter treatment						
		a need to discontinue an						
	_	reatment due to adverse						
		r to commence a new form a decision to transfer or						
		sident from the facility as						
	specified in §483.							
		also promptly notify the						
		nown, the resident's legal						
	•	interested family member						
	when there is a cl	ment as specified in						
		a change in resident rights						
		State law or regulations as						
		graph (b)(1) of this section.						
		record and periodically						
		ss and phone number of						
	interested family	al representative or						
	mileresieu iamiliy i	member.	F01	57	E4E7 Notify of Observe		10/10/2012	
	Dagad are alease	ation intomious and	FUI	<i>31</i>	F157 Notify of Changes (Injury/Decline/Romm,ETC) It	ie	10/10/2012	
		ation, interview, and			the policy of the facility that the			
	-	ne facility failed to ensure			facility will immediately inform			
	the family and pl	hysician were notified of			resident; consult with the			
	a new pressure a	rea, for 2 of 3 residents			resident's legal representative	or		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I5XK11

Facility ID: 000129

If continuation sheet Page 3 of 24

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPLI	ETED
		155224				09/26/2	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
00111145		OFNITED			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed for pre	essure areas, in a sample			an interested family member		
	of 24. Resident				when there is am accident		
	or 24. Resident	. D und C			involving the resident which		
77' 1' ' 1 1				results in injury and has the			
Findings include:				potential for requiring physicia			
	1. On 9/24/12 at 2:10 P.M., during the initial tour, LPN # 1 indicated Resident B				intervention; a significant chan		
					in the resident's physical, men		
					or psychosocial status; a need		
	had a pressure area on her right heel.				alter treatment significantly; or decision to transfer or discharge		
	*	observed sitting up in her			the resident from the facility.	ا	
					What corrective action(s) will	.	
	wheelchair with her feet flat on the floor				be accomplished for those	-	
		per socks. LPN # 1			residents found to have been	,	
	removed the resi	ident's sock, and a dry,			affected by the deficient		
	brownish, pressu	ire area was observed on			practice?		
	the right heel. Tl	here was no dressing on			·Resident B and C primary		
	_	1 indicated she thought			physicians have been notified	of	
		receiving skin prep to the			all skin impairments.		
		receiving skin prep to the			How will you identify other		
	area.				residents having the potentia	al	
					to be affected by the same		
	The clinical reco	ord of Resident B was			deficient practice and what		
	reviewed on 9/2	25/12 at 9:20 A.M.			corrective action will be take		
					·Residents with a change of		
	Δ "Weekly Sum	mary," dated 9/19/12 at			condition have the potential to		
	I	eated, "Does the resident			affected by the alleged deficient practice	111	
	•				·The licensed nurses have b	een	
		following, Open areas -			re-educated on residents char		
	inner left heel/re	ed & open"			of condition, and the skin	.5-	
					management program. Timely	,	
	Documentation t	that the physician or			notification of physician and		
		ied of the new open area			family of change of condition.		
	was not in the cl	-			Completed by DNS/SDC by		
		of a new treatment order			October 7, 2012.		
					·The DNS /designee is	,,,	
	was not observed	d in the clinical record.			responsible to ensure complia ·Skin sweeps were complete		
					on all residents and any	tu	
	On 9/25/12 at 10	):45 A.M., a skin			impairment reported to		
	assessment was	again requested on			physicianWhat measures will	be	
		•	1		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 155224  NAME OF PROVIDER OR SUPPLIER  COLUMBIA HEALTHCARE CENTER  IDENTIFICATION NUMBER: 155224  STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  Regulatory or LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  Result on the label of the label	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
NAME OF PROVIDER OR SUPPLIER  COLUMBIA HEALTHCARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710  (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY) DATE  Put into place or what systemic changes you will make to ensure that the deficient	AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	I DING	00	COMPLI	ETED
NAME OF PROVIDER OR SUPPLIER  COLUMBIA HEALTHCARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710  (EACH CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  put into place or what systemic changes you will make to ensure that the deficient			155224				09/26/2	2012
COLUMBIA HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PREFIX Resident B was observed lying in bed, with her heels flat on the				P. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
COLUMBIA HEALTHCARE CENTER  EVANSVILLE, IN 47710  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  EVANSVILLE, IN 47710  (X5) PREFIX COMPLETION TAG  PREVIDENCE OF THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PROVIDEN'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  Put into place or what systemic changes you will make to ensure that the deficient	NAME OF PR	ROVIDER OR SUPPLIER						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  PREFIX TAG  PREFIX PREFIX PREFIX TAG  COMPLETION DATE	COLUMBI	IA HEALTHCARE	CENTER					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Resident B. Resident B was observed lying in bed, with her heels flat on the  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  PREFIX TAG		SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
Resident B. Resident B was observed lying in bed, with her heels flat on the	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
lying in bed, with her heels flat on the changes you will make to	-		· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCY)		DATE
lying in occ, with her needs that on the		Resident B. Res	ident B was observed				nic	
ensure that the deficient		lying in bed, wit	h her heels flat on the					
I hed KN # / indicated the resident had I I I I I I I I I I I I I I I I I I I	bed. RN # 2 indicated the resident had							
practice does not recur?								
heel, and was receiving skin prep to both  The licensed nurses have been re-educated on resident change		-	<del>-</del>					
							J <del>C</del>	
management program Timely		of the areas. The resident's left inner heel					,	
natification of physician and	had a dry brownish area. RN # 2 indicated						,	
the resident should have had her heels family change of condition.								
floated to relieve pressure on her heels.  Completed by DNS/SDC by	floated to relieve pressure on her heels.					Completed by DNS/SDC by		
October 7, 2012.								
On 9/26/12 at 10:00 A.M., during		On 9/26/12 at 10	0:00 A.M., during				ill	
interview with the Director of Nursing			•					
management to identify and			•					
			· ·					
Wooldly Cummarica/Ckin								
physician to see if he had documentation assessment forms will be audited							ited	
of notification of the new area, because by nurse managent 5x weekly to								
she was sure staff had notified him. No identify any changes in condition		she was sure stat	f had notified him. No					
further documentation was received by and ensure physician notification.		further documen	tation was received by				ion.	
survey exit on 9/26/12 at 3:00 P M								
conducted 5x weekly with		<i>j</i> ,	· · · · ·					
members of the IDT to communicate with residents and		2 On 9/24/12 of	2:10 P.M. I PN # 1					
may be compared to the compared to			in C nau a pressure area					
on her foot.		on her foot.						
physician/family is notified and an							d an	
On 9/25/12 at 8:40 A.M., a wound appropriate treatment is obtained.		On 9/25/12 at 8:	40 A.M., a wound					
assessment was requested. PTA # 1 • The DNS/designee is		assessment was	requested. PTA # 1			_		
(Physical Therapy Assistant) indicated the responsible to ensure compliance		(Physical Therar	by Assistant) indicated the					
Non-compliance with these		` ' '	,					
procedures and training will result		-					SUIT	
" " " " " " " " " " " " " " " " " " "								
			•				he	
deficient practice will not require			•					
dressing to the areas. The resident had a		<del>-</del>					····,	
pressure area on her left heel that was program will be put into place?		pressure area on	her left heel that was				e?	
observed to be dry and brown. PTA # 1 • The change of condition CQI		observed to be d	ry and brown. PTA # 1					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155224	A. BUILDING B. WING		09/26/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		COLUMBIA ST	
COLUME	BIA HEALTHCARE	CENTER		SVILLE, IN 47710	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ge was undetermined,		toll will be utilized weekly x4 weeks, monthly x 3 months ar	nd
	1	pears to have a small		quarterly thereafter. For a	iu
	opening in the middle." An additional			minimun of 6 months.To be	
	pressure area wa	as observed on the		completed by DNS/designee	
	resident's left ou	ıter ankle.		·All audit tools will be brough	nt
	The clinical record of Resident C was			before the CQI committee	
				monthly Any non-compliant issues r	nav
	reviewed on 9/2	5/12 at 10:00 A.M.		be addressed with re-education	
	A "Therapy Wound Eval [evaluation] and Plan of Care" included: "Observation			and/or disciplinary action up to	
				and including termination.	
				Compliance date: October 10	),
	Date: 9/20/2012- 2:55 P.MPT [physical			2012	
	therapy] wound re-certificationReason				
		nds on left lateral			
	malleolus and le				
		r, 1. left lateral malleolus			
	2. Left heel, Sta	~			
	_	Suspected origin,			
		.Wound color 1. black			
	1 '	ellow, Necrotic Slough			
	` ′ ′ ′ ′	sh (description) -			
	1 -	t Tx [treatment] order,			
	wound care, deb	oridement and dressing"			
		ound Skin Evaluation			
	Report" include	d: "Event Date: 9/20/12			
	9:05 A.M., Com	pleted Date: 9/25/2012-			
	9:07 A.MNew	area, Wound present on			
	admission, No,	Date area originally noted			
	09/20/2012, Sta	ge			
		ecrotic/eschar (Black,			
	_	sue adheres to wound			
	bed), Site left he				
		n cm [centimeters]4 x			
		i oiii [continuctois] ¬ A			

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	OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155224	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 09/26/2012
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	621 W (	ADDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	1.5 x utd [undetermined]"  The most recent wound care order, dated 8/23/12, indicated, "Clean O/A [open area] to [right] inner ankle [and] [left] outer ankle [with] NS [normal saline] apply Santyl, 2x2 gauze [and] allevyn, [change] daily." The resident's treatment record indicated this treatment was to be completed Monday-Friday by therapy, and Saturday and Sundays by nursing.  Documentation that the physician or family was notified of the new pressure area was not observed in the clinical record.  On 9/26/12 at 11:30 A.M., during interview with the Director of Therapy, Director of Nursing [DON], Administrator, and PTA #1, the DON indicated therapy was already treating the resident, and notified the physician by sending the physician the therapy plan of care on 9/20/12. The Director of Therapy indicated the plan of care was probably lying on the physician's desk, waiting to be signed.  On 9/26/12 at 2:00 P.M., the Director of Therapy plan of care, dated 9/26/12, signed by the Nurse Practitioner.			

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224		LDING	NSTRUCTION  00	(X3) DATE COMPL 09/26	ETED
ROVIDER OR SUPPLIER			621 W C	DDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710		
SUMMARY S' (EACH DEFICIEN REGULATORY OR  3. On 9/26/12 at Administrator pr facility policy or Condition," revisincluded: "It is that all changes is be communicate family/responsible appropriate, time intervention occurrence (Change, a. All sy will be documen and communicate physician promp is responsible for and family/responsible for any family	CENTER  FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  1:30 P.M., the ovided the current a "Resident Change of Sed 3/10. The policy ne policy of this facility n resident condition will d to the physician and le party, and that ely, and effective arsRoutine Medical comptoms and usual signs ted in the medical record ed to the attaining tlyThe nurse in charge or notification of physician ensible party prior to end	B. WIN	STREET A	COLUMBIA ST	3	(X5) COMPLETION DATE

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Event ID: I5XK11

Facility ID: 000129

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PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. E.		A. BUILDING B. WING  O0  COMPLETED 09/26/2012						
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W COLUMBIA ST EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			

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Event ID: I5XK11

Facility ID: 000129

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIC	00	COMPLE	ETED
		155224		LDING		09/26/2	2012
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
COLLIME		CENTED			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	REGULATORY OF 483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be persons in according written plan of case and care record review, the physician's comedication admiresidents sample orders and care Resident G  Findings includ  1. On 9/24/12 are observed to admire community of the community of the community of the current septing indicated, "Community of the	QUALIFIED PERSONS/PER  ovided or arranged by the provided by qualified redance with each resident's are.  ovation, interview, and the facility failed to ensure order was followed for an inistration for 1 of 23 and related to physician plans, in a sample of 24.  e:  t 4:45 P.M., RN # 1 was minister to Resident G and a medication used for ease].  ord of Resident G was 24/12 at 6:05 P.M. A cr., dated 7/25/11 and on member 2012 orders, man 200 mg. Take one 3 times daily 0800 [8:00 00 P.M.] 2000 [8:00	F02	TAG	CROSS-REFERENCED TO THE APPROPRIA	e es ce an or erse dent ent y ing	
	-	dication Administration			·All residents that reside with	I	
	Record also ind	icated the medication was			the facility have the potential to		
	to be given at 8	:00 A.M., 2:00 P.M., and			affected by the alleged deficie	nt	
	8:00 P.M.				practice.		
	2.00 2 .1.1.				·What measures will be put	t	
	0:: 0/24/12 : 6	.05 D.M. 1			into place or what systemic		
	On 9/24/12 at 6	:05 P.M., during interview			changes you will make to		

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Event ID: I5XK11

Facility ID: 000129

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155224	B. WIN			09/26/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
COLLINA		CENTER			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVAINS	VILLE, IN 47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with RN # 1, sh	e indicated "it was the			ensure that the deficient	•	
	· ·	vas working alone, and she			practice does not recur?		
		•			· All nurses/QMAs that pass		
		given the Comtan until			medications in the facility have	;	
	closer to 8:00 P	.M.			received training in regards to	the	
					five rights of medication		
	2. On 9/27/12 a	t 1:30 P.M., the			administration. Completed		
		provided the current			by SDC/DNS/designee by		
					10/10/2012.		
	facility policy of				·Medication pass validation t		
		Guidelines," dated			has been implemented by nurs	se	
	7/2011. The pol	licy included:			management.		
	"Medications	can be administered			·Nurses/QMAs will not be		
		ur time frame ( one hour			released out of orientation unti	ıl a	
					member of the nurse		
		our after the time			management team has		
	prescribed)Be	fore giving a medication			completed a medication pass		
	the nurse must	follow the FIVE			validation tool		
	'R's'THE RIG	HT TIME "			<ul> <li>All nurses/QMAs that pass medications in the facility have</li> </ul>		
	1101112.1110				received training in regards to		
	TEL: C. 1. 1.	1			five rights of medication	uic	
	_	relates to Complaint			administration. Completed		
	IN00116529.				by SDC/DNS/designee by		
					10/10/2012.		
	3.1-35(g)(2)				· Nurses/QMAs must pass th	ne	
	(6)(-)				medication validation tool erro		
					free before passing meds		
					independantly in the facility.		
					·10% of nurses/QMAs will be	Э	
					observed utilizing the medicati	on	
					pass validation tool monthly by	/	
					nurse managers to be conduct	ted	
					by all shifts.		
					·Addendum: All physician		
					orders were reviewed and aud	lited	
					by nurse management by		
					September 31 and verified on		
					new MAR for October 1		
					implementation. An audit of all		
					orders was completed at this		
					time.How the corrective		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORREC	CTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155224	B. WIN	NG		09/26/2012
NAME OF PROVIDER (	OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					COLUMBIA ST	
COLUMBIA HEAL	THCARE (	CENTER		EVANS	VILLE, IN 47710	
` ′		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
· ·		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG REGU	LATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					action(s) will be monitored to	
					ensure the deficient practice will not recur, i.e., what quali	
					assurance program will be p	
					into place?	
					·All Nurses/QMAs have bee	n
					educated on the five rights of	
					medication administration.	_
					·10% of nurses/QMAs will be observed utilizing the medicat	
					pass validation tool monthlyu.	
					·The DNS /designee will	
					complete medication error CQ tool 5X weekly X 4 weeks, we	
					X 4, and quarterly thereafter. If	
					a minimum of 6 months	
					·All audit tools will be brough	nt
					before the CQI committee	
					monthly	201
					<ul> <li>Any non-compliant issues no be addressed with re-education</li> </ul>	
					and/or disciplinary action up to	
					and including termination.	
					Compliance date: October 10	),
					2012	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155224	B. WIN		·	09/26/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER				COLUMBIA ST		
	SIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY		DATE
F0314 SS=D	483.25(c) TREATMENT/SV PRESSURE SOF Based on the con a resident, the face resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promo infection and previous developing.  Based on observer record review, the the physician of obtain treatment pressure relief, to ulcers, for 1 of 3 pressure ulcers, in Resident B  Findings include  1. On 9/24/12 at initial tour, LPN had a pressure an Resident B was of wheelchair, with wearing slipper se the resident's soo pressure area was heel. There was a	inprehensive assessment of cility must ensure that a sers the facility without the period of the per	F03	TAG	F314 Treatment/svcs to prevent/heal pressure sores is the policy of the facility that facility must ensure that a resident who enters the facility without pressure sores does n develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receive necessary treatment and servito promote healing, prevent infection and prevent new sore from developing What correct action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident B has been evaluate by therapy for proper wheelched positioning.  Resident B has appropriate treatment order in place.  Resident B has appropriate pressure relieving devices	It the ot son sces es ive ed air	DATE  10/10/2012
		eiving skin prep to the			ordered and care planned.  How will you identify other		
	resident was lett	aving skin prop to the	1		i now will you lucifully office		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
		155224	B. WIN			09/26/2012
			b. Wil		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER			COLUMBIA ST	
COLLIME	BIA HEALTHCARE	CENTER			SVILLE, IN 47710	
	,					<u>,                                      </u>
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	-	TAG	,	DATE
	area.				residents having the potentia	31
					to be affected by the same deficient practice and what	
	On 9/24/12 at 3	:55 P.M., Resident B was			corrective action will be take	m2
	observed sitting	g in a wheelchair with her			·All residents that have	
	feet flat on the	floor.			pressure wounds have the	
					potential to be affected by the	
	The clinical rea	ord of Resident B was			alleged deficient practice.	
					· Care plans of any resident	
	reviewed on 9/2	25/12 at 9:20 A.M.			with pressure wounds have be	een
					reviewed and updated if	
	Physician orders, initially dated 4/19/12 and continued on the September 2012				indicated.	
					·Nurse managers will round	
	orders, indicated, "Skin prepApply to				daily to ensure proper pressur relieving/reducing devices are	l l
	left heel every	shift Leave open to air."			place for any resident that has	
		same zewye open to um.			pressure related wounds and	´
	A some mlam day	tad 5/2/12 indicated			C.N.A. assignment sheets have	/e
	•	ted 5/2/12, indicated,			been updated according to ca	
	•	dent has impaired skin			plan.	
		ure area to right heel." The			·Audit has been completed t	•
	Approaches inc	eluded: "Pressure			DNS to ensure any resident w	ith
	reducing/redistr	ribution cushion in chair,			pressure wounds has the	
	Pressure reduci	ng/redistribution mattress			appropriate treatment in place and physician has been updat	l l
		ent as ordered, Turn and			with current measurements ar	
	reposition ever				assessment of pressure woun	
	reposition ever	y 2 Hours			·Addendum: Skin sweep wa	l l
	A Minimum D	A. C. IMDCI			completed on 10/4/2012 by nu	ırse
		ata Set [MDS] assessment,			management	
	1	indicated the resident			What measures will be put in	nto
	scored a 3 out of	of 15 for cognition, with 15			place or what systemic	
	indicating no m	nemory impairment. The			changes you will make to	
	MDS assessme	nt indicated the resident			ensure that the deficient	
	required extens	ive assistance of two+			practice does not recur?	
	_	obility and transfer, and did			·Licensed nursing staff has been educated on wound	
		The MDS assessment			prevention policy by DNS/SD0	C by
					10/10/2012.	,
		sident had 1 unhealed			·DNS/Designee/UM will con-	duct
	pressures ulcer,	, which was a Stage 2.			rounds daily on all shifts to	
					validate that all pressure	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155224	B. WIN			09/26/2012
CE OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L		621 W (	COLUMBIA ST	
	BIA HEALTHCARE (				VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	1	mary," dated 9/19/12 at			reducing/relieving intervention are in place and functioning	IS
	· ·	ated, "Does the resident			properly.	
	1	following, Open areas -			·C.N.A. assignment sheets	
	inner left heel/re	d & open"			have been updated to reflect	
					current measures according to	
	Documentation t	hat the physician or			plan of care.	
	family was notif	ied of the new open area			How the corrective action(s) will be monitored to ensure to	
	was not in the cl	inical record.			deficient practice will not rec	
	Documentation of	of a new treatment order			i.e., what quality assurance	<del></del> ,
	was not observed	d in the clinical record.			program will be put into place	e?
					·Staff has been educated on	
	A "Pressure Wo	und Skin Evaluation			wound prevention policy.	
		ted 9/25/12 at 8:48 A.M.,			·The DNS/designee will	
		ght heel, existing area,			complete wound CQI tool 5X weekly X 4 weeks, weekly X 4	
	·				and quarterly thereafter. For a	,
	•	on admission, YesStage			minimum of 6 months	
		Describe wound			·All audit tools will be brough	t
	drainage, scant s	erous"			before the CQI committee	
					monthly  ·Any non-compliant issues m	201/
		):45 A.M., a skin			be addressed with re-educatio	
		again requested on			and/or disciplinary action up to	
	Resident B. Res	ident B was observed			and including termination.	
	lying in bed, with	h her heels flat on the			Compliance date: October 10	,
	bed. RN # 2 ind	icated the resident had			2012	
	pressure areas or	n both the right and left				
	heels, and was re	eceiving skin prep to both				
	of the areas. The	resident's left inner heel				
	had a dry brown	ish pressure area. The				
	<u>-</u>	uter heel had a pressure				
	_	ared dry and brown. RN				
		resident should have had				
		to relieve pressure on her				
		idicated the resident had				
		e ulcers on her heels,				
	which had not re	esponded well to				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE : COMPL		
THEFTERN	or condition	155224		LDING		09/26/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00:20:	
NAME OF P	PROVIDER OR SUPPLIER				COLUMBIA ST		
COLUME	BIA HEALTHCARE (	CENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
	_	ntments, and that is why					
	the areas were le	ert open to air.					
	On 9/26/12 at 10	0:00 A.M., during					
		ne Director of Nursing					
		ninistrator, the DON					
		nt B had a previous					
		the left heel which had					
	•	skin prep, and she					
		ician had been notified to					
	continue the skir						
		s not treating the area as					
		pecause although it had					
		pressure area, she thought					
		lue to a previous fall.					
	it had occurred a	ac to a provious rain.					
	2. Stages of Pres	ssure Ulcers, AMDA					
	(American Medi	cal Director's					
	Association) - 20	008, included: Stage II:					
	Partial thickness	loss of dermis presenting					
	as a shallow ope	n ulcer with a red pink					
	ulcer bed withou	t slough. May also					
	present as an inta	act or open/ruptured					
	serum filled blist	ter. Note: This stage					
	should not be use	ed to describe skin tears,					
	tape burns, perin	eal dermatitis,					
	maceration or ex	coriation. Stage III: Full					
	thickness tissue l	loss. Subcutaneous fat					
	may be visible b	ut bone, tendon or muscle					
	is not exposed. S	Slough may be present					
	but does not obse	cure the depth of tissue					
	loss. May includ	de undermining and					
	tunneling.						

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PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155224	A. BUILDING  B. WING	00	COMPI 09/26	ETED
	PROVIDER OR SUPPLIER BIA HEALTHCARE CENTER	621 W (	ADDRESS, CITY, STATE, ZIP COD COLUMBIA ST VILLE, IN 47710	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	3. On 9/26/12 at 1:30 P.M., the Administrator provided the current facility policy on "Skin Management Program," revised 6/12. The policy included: "Alterations in skin integrity will be reported to the physician and family member(s). Physician orders will be obtained for all alterations in skin integrity identifiedPressure reduction devices are to be put in place immediatelyThe care plan will be initiated/revised addressing any new areas"  This federal tag relates to Complaint IN00116529.  3.1-40(a)(1) 3.1-40(a)(2)				

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PRINTED: 10/25/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155224	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMPI 09/26	LETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODI COLUMBIA ST	3	-
COLUME	BIA HEALTHCARE	CENTER		VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155224	A. BUII B. WIN			09/26/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER			VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0329 SS=D	from unnecessary drug is any drug of dose (including descessive duration monitoring; or with for its use; or in the consequences where should be reduce combinations of the sased on a comparesident, the facility residents who has drugs are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual descent behavioral interverse ontraindicated, in these drugs.  Based on interviting facility failed to indications for the medication, Loral	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for in; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above.  orehensive assessment of a ity must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to ondition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue  ew and record review, the ensure adequate the use of an anti-anxiety azepam, for 1 of 3	F03	29	F329 Drug regimen is free frounnecessary drugs It is the policy of the facility that each resident's drug regimen is free from unnecessary drugs. What		10/10/2012
		ed receiving psychotropic			corrective action(s) will be		
	medications, in a	sample of 24.			accomplished for those		
	Resident A				residents found to have been	ı	
	Findings include  1. The closed cli	: nical record of Resident			affected by the deficient practice? Resident A no longer reside the facility. How will you idention other residents having the		
		on 9/25/12 at 1:15 P.M.			potential to be affected by the	е	
		ded, but were not limited			same deficient practice and		
	Diagnoses includ	ica, out were not infined			-		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		155224	B. WIN			09/26/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
COLLINA	BIA HEALTHCARE	CENTED			COLUMBIA ST VILLE, IN 47710	
COLUME	DIA REALTRUARE	CENTER		EVAINS	VILLE, IN 477 IU	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	to, dementia.				what corrective action will be	
					taken?	
	The recident was	s admitted to the facility			·All residents that have an	
		· ·			order for PRN antianxiety	
	on 4/25/12. A Physician's order, dated				medication have the potential	to
		ed, "Lorazepam 0.5 mg,			be affected by the alleged	
	Take 1 tablet by	mouth 3 times daily as			deficient practice.	
	needed for anxiety/agitation (For Ativan				·Every resident's medication regimen has been reviewed by	
	0.5 mg)."				SS and Nurse management.	<b>'</b>
					·Medication changes have b	een
	The magidentia M	Indication Administration			made according to the resider	
	The resident's Medication Administration Record [MAR], dated June 2012,				needs.	
					·Any new admission that adi	mits
	indicated the resident received Lorazepam				to the facility with a	
	on June 5, 7 and	June 18. The reverse			PRN antianxiety order will be	
	page of the MAI	R indicated:			placed on a clinical monitoring	
					tool to be reviewed by IDT with	nin
	"6 7 12 Ativan	0.5 mg 1600 [4:00 P.M.]			7 days to determine if med is	
		• •			appropriate.	
		gitation, anxiety." The			. What measures will be put	
	_	se" section was left			into place or what systemic	
	blank.				changes you will make to ensure that the deficient	
					practice does not recur?	
	"6-7-12- 2315 [1	1:15 P.M.] Ativan 0.5			·Licensed nursing staff have	
	_	mouth] [increased]			been educated on proper	
		y. Results/Response			procedure to document and	
		•			administor PRN antianxiety	
	effective 0015 [	12:15 A.M.J.			medication and taught	
					appropriate interventions to	
	6-18-12, time ill	egible, Ativan 0.5 mg			attempt prior to medication	
	[one] po agitatio	n. Results/Response			administration. Completed by	
	slightly effective	e [time illegible]."			SDC/DNS by 10/10/2012	
		r 2 1.			·SSD/DNS must be notified	NDA I
	Nurging progress	s notes did not address			prior to administration of any F	KIN
	0.0	s notes did not address			Antianxiety  DNS/designee will review	
		itation on 6/7/12. A			<ul> <li>DNS/designee will review narcotic count sheet and MAR</li> </ul>	of
	progress note, da	ated 6/8/12 at 2:00 A.M.,			any resident with a PRN order	
	indicated, "Sleep	oing quietly @ this time,			Antianxiety daily to ensure that	
	was given Ativa	n earlier d/t [due to]			nonpharmacological interventi	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155224		LDING		09/26/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
0011114		OFNITED			COLUMBIA ST		
COLUME	BIA HEALTHCARE	CENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	increased agitati	on and anxiety.			were attempted prior to	•	
		effective. Safety			administration. How the		
					corrective action(s) will be		
	measures are in place and functioning.				monitored to ensure the		
		he Ativan, po fluids, food,			deficient practice will not rec	ur,	
	going to BR [bat	throom], and 1:1 was			i.e., what quality assurance		
	done."				program will be put into plac		
					Staff have been educated o		
	Nursing progress	s notes did not address			proper procedure to document		
		itation on $6/18/12$ .			and administor PRN antianxie	•	
	the resident's agi	ttation on 0/18/12.			medication and interventions t	0	
					attempt prior to medication administration. Completed by		
	The MAR, dated July 2012, indicated the				SDC/DNS by October 12, 201	2	
	resident received	d Lorazepam on 7/10,			CD 0/D110 by Colobbi 12, 201		
	7/19, 7/25, and 7	7/27. The reverse of the			·The Social Services Directo	r	
	MAR document	ed one entry that the			/designee will complete CQI to	ool	
		the Lorazepam, on			5X weekly X 4 weeks, weekly	Χ	
		ntry indicated, "[Time			4, and quarterly thereafter. For	ra	
					minimum of 6 months		
		epam 0.5 [one] po, Reason			·All audit tools will be brough	nt	
	•	Response effective 2100			before the CQI committee		
	[9:00 P.M.]."				monthly ·Any non-compliant issues n	201/	
					be addressed with re-educatio		
	Progress notes d	id not address the			and/or disciplinary action up to		
	resident's anxiet				and including termination.		
	i o si do si di si	, 611 // 16/ 12:			Compliance date: October 10	),	
	D	1-4-17/10/12 -4 1.45			2012.	•	
		dated 7/19/12 at 1:45					
	P.M., indicated,						
		compliant with waiting					
	for assistance in	getting up. Attempts to					
	get out of bed ar	nd w/c [wheelchair] by					
	herself"						
	Thomas 1.	commentation on 7/10/12					
		ocumentation on 7/19/12,					
		12 regarding increased					
	agitation or anxi	ety.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155224	B. WIN			09/26/	2012
NAME OF P	PROVIDER OR SUPPLIEF	\ \			DDRESS, CITY, STATE, ZIP CODE		
COLLIME		CENTED			COLUMBIA ST		
	BIA HEALTHCARE			<u> </u>	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>	+	TAG			DATE
		1 8/12, indicated the 1 Lorazepam on 8/21 and					
		*					
	8/26. The reverse of the MAR did not include documentation for the reason of						
	the medication.						
	A Progress note	dated 8/22/12 at 10:40					
	A Progress note, dated 8/22/12 at 10:49 P.M., indicated, "Very agitated earlier. Refused all meds and was yelling out.						
		er colostomy bag, which					
		5 0.					
	was replaced. Finally able to get resident to take a dose of prn [as needed] Ativan, crushed in yogurt."						
	Crushed in yogu	t.					
	The nevt entry	lated 8/26/12 at 5:19					
		"Agitated and yelling					
		lose of Ativan and given					
	pudding. Taken	•					
	[daughter]."	to room per Du					
	[uauginer].						
	A care nlan date	ed 7/23/12, indicated:					
		vior: [Resident A] has					
		g very restless, yells out,					
		ic]ApproachesGive					
	_	prevent behaviors from					
	occurringUse l	•					
	_	as [Resident A] is very					
	_	.Provide reassurance that					
		ourage family to visit and					
	be supportive as	•					
	oc supportive as						
	On 9/26/12 at 10	0:00 A.M., during					
		ne Administrator and					
		ing [DON], the DON					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155224	LDING	NSTRUCTION  00	(X3) DATE COMPL 09/26/	ETED
	PROVIDER OR SUPPLIER		621 W C	DDRESS, CITY, STATE, ZIP CODE COLUMBIA ST VILLE, IN 47710		
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
	indicated the face behavior program obtain better docuse of prn medical Administrator in Resident A "wan Ativan."  2. On 9/26/12 at Administrator profacility policy or Medication Manundated. The policy of [facility that a resident's pregimen helps profighest practical psychosocial we medications are with the attendinand facility staff interventions, as as applicable"  On 9/26/12 at 1:: Administrator profacility policy or Administrator profacility policy or Administrator profacility policy or Administration On T/2011. The policy or Administration of T/2011. The policy of T/2011. The policy of T/2011. The policy of T/2011. The policy of T/2011.	cy MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  ility began a new in on 8/1/12, to try and umentation for when the ations are used. The dicated the family of ited her to have the  1:30 P.M., the ovided the current in "Psychotropic agement Program," icy included: "It is the by corporation] to ensure osychotropic medication comote the resident's ole mental, physical and ill-being. These managed in collaboration g physician, pharmacist to include behavioral sessment and reduction  30 P.M., the ovided the current		(EACH CORRECTIVE ACTION SHOULD BE	ATE	
		on must be documented es, or in the area provided				

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER:  155224	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 09/26	LETED
	ROVIDER OR SUPPLIER IA HEALTHCARE CENTER	621 W	ADDRESS, CITY, STATE, ZIP COI COLUMBIA ST SVILLE, IN 47710	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	for PRN documentation on the medication administration record"				
	This federal tag relates to Complaint IN00116529.				
	3.1-48(a)(4)				

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